WRITTEN TESTIMONY PETER J. DUFFY
DEPUTY DIRECTOR LEGISLATION
NATIONAL GUARD ASSOCIATION OF THE UNITED STATES
BEFORE THE
UNITED STATES SENATE MILITARY PERSONNEL
SUBCOMMITTEE OF THE ARMED SERVICES COMMITTEE

Chairman Jim Webb
Ranking Member Lindsey Graham
Members of the Subcommittee

Thank you for the opportunity to present written testimony on behalf of the National Guard Association of the United States to address critical personnel issues facing members of the National Guard and their families. This brief submission will provide factual background, analysis and corrective recommendations for the Committee to consider.

The Unique Citizen Service Member

The National Guard is unique among components of the Department of Defense in that it has the dual state and federal mission. While serving operationally overseas on Title 10 active duty status, National Guard units are under the command and control of the President. However, upon release from active duty, members of the National Guard return to the far reaches of their states under the command and control of their governors where as a special branch of the Selected Reserves they train not just for their federal missions but for their potential state active duty missions such as protecting the border and airspace, fire fighting, flood control and providing assistance to civil authorities in a variety of possible disaster scenarios.

Activation numbers for the National Guard as of April 5, 2011 are as follows:

Guardsmen Currently Activated in Support of Operations NOBLE EAGLE / ENDURING FREEDOM / NEW DAWN (as of April 5)
ARNG: 43,288
ANG: 5,637

Total Guardsmen Activated in Support of Operations NOBLE EAGLE / ENDURING FREEDOM / NEW DAWN (Since 9/11)
ARNG: 342,446
ANG: 87,103

While serving in their states, members are scattered geographically with their families as they hold jobs, own businesses, pursue academic programs and participate actively in their civilian communities. Against this backdrop, members of the National Guard remain ready to uproot from their families and civilian lives to serve their governor domestically or their President in distance parts of the globe as duty calls and to return to the same communities when their missions are accomplished.

Military service in the National Guard is uniquely community based. The culture of the National Guard remains little understood outside of its own circles. When the Department of Defense testifies before Congress stating its programmatic needs, it will likely recognize the indispensable role of the National Guard as a vital operational force in the current wars but it will say little and seek less to address the benefit disparities, training challenges and unmet medical readiness issues that exist for National Guard members and their families at the state level before, during and after deployment. The National Guard Association of the United States asks this Sub Committee to please understand that the personnel issues of the National Guard are different from those of the active forces, and in some cases radically so. We ask that they be given a fresh look with the best interests of the National Guard members and their families in mind in reviewing the recommendations set forth below.

Support for Individual Medical Readiness Needs

According to The Task Force on the Future of Military Health Care, "Today's Operational Tempo raises the importance of all responsible parties doing their part to ensure the Individual Medical Readiness (IMR) requirements are satisfied to facilitate maximum deployability of our forces."

The Department of Defense (DoD) requires all members of the National Guard to be medically ready as a condition for deployment. IMR must address the medical and dental needs of those members deploying for the first time as well as those subject to redeployment whose mental health care

needs arising from prior service in OIF and OEF have become paramount. However, using the National Guard as an operational force requires more accessible health care particularly mental health care for members and their families pre and post deployment in order to maintain the necessary medical readiness required by deployment cycles. It cannot be a simple post deployment send off by the active military of "Good job. See you in three years."

The Department of Defense must do more to bring the National Guard to a constant state of medical readiness to better support the short notice deployments that occur regularly within the National Guard. For example, the Air National Guard must maintain constant dental and medical readiness because of the short notices they receive for deployments, which sometimes can be as little as 72 hours. Short notice deployments also occur regularly with cross leveled members who, with as little as two or three weeks notice, must fill in for members from other deploying units who for various reasons become disqualified for deployment. Members in the pool of Individual Mobilization Augmentees (IMAs) whose files are kept at the Human Resources Command in St. Louis can also be assigned to fill positions in deploying units on short notice without the benefit of the pre mobilization preparations taking place in the deploying unit.

The Army National Guard currently has the highest suicide rate in the military yet there remains no authority in Title 10 to authorize the Service Secretaries to provide mental health care for our members during dwell time to maintain readiness. In fact, outside of the deployment windows which extend from the issuance of an alert order to the close of the 6 month TAMP period following deployment, there is no authority for the Service Secretaries to provide any care beyond fixing dental readiness issues identified in annual screenings.

Commanders currently lack the tools during dwell periods to fix medical and behavioral readiness issues identified during annual screenings identifies. The government pays good money to identify treatable medical and behavioral readiness conditions but no money to fix them during dwell time. This heightens the risks that members with untreated conditions that otherwise could have been fixed will be deployed only to be released from active duty at the mobilization stations because of the untreated condition. This in turn sets into motion the difficult cross leveling process with the unit losing key personnel at the worst time and a surrogate stepping in on very

short notice at great hardship to the member and the member's family. This problem is solvable but Congress must act by giving the Service Secretaries discretionary authority to correct treatable medical and behavioral readiness deficiencies discovered during dwell time screenings. Members with conditions that cannot be corrected can be separated or reassigned in a more timely manner outside of deployment windows. This would allow for a more medically and dentally ready deployable force even before the issuance of alert notices. This in turn would help to limit the time diverted for treatment during the training intensive alert periods.

Recommendation:
The National Guard Association of the United States recommends that the National Guard Bureau, the Department of Defense, and the Congress of the United States support authorization and appropriations for programs that will:

- Amend 10 USC 1074 a(f)(1) to authorize Service Secretaries provide the treatment needed to correct treatable readiness deficiencies identified during dwell time screenings.

Post Deployment Health Assessments and Medical Screenings at the Home Station

It is imperative post deployment that our members while still on active duty deployment orders be examined confidentially at the home station by a qualified health care providers in order to address the under reporting of physical and mental health conditions that is occurring on the self administered Post Deployment Health Assessment(PDHA). The PDHA is currently being completed by a homeward bound member in theater or at the demobilization site often several states away from home.

When the PDHA is completed, it is accompanied with the instruction that the self assessing member may be medically held on active duty at the demobilization site if he or she reports a medical condition requiring that action. To avoid the risk of being held at the demobilization site after a long deployment, members are simply not fully reporting their physical and behavioral injuries. This underreporting not only delays treatment but can prejudice later claims with the VA for service connected disabilities arising from conditions not previously reported on the PDHA.

What is needed forthwith is a free and confidential reporting of physical and mental health conditions at the home station by all members, stigma free, to a health care provider trained to elicit that information and to screen for those conditions without the fear of being medically held far from home. If medically holding the member is advisable, it should be done as close to home as possible.

The irony in the current PDHA under reporting phenomenon is that a medical hold is usually in the best interest of the member and his or her family as it allows pay and benefits to continue during treatment for a condition that may well render the member unemployable once discharged. The medical hold should not cynically be administered as a threat to discourage reporting of injuries when, if properly administered in a friendly environment, it offers substantial benefits to the members and his or her family.

The PDHA needs to be completed by returning members at home in the presence of a trained health care professionals who can screen, observe and ask with the skill necessary to elicit medical issues either unknown to the self reporting member or unreported for fear of being retained at far removed demobilization site. Insurance companies in performing their due diligence before the issuance of an insurance policy do not allow individuals to self assess their health. Neither should the military. If geographical separation from families is causing under reporting and non reporting of physical and psychological combat injuries on the PDHA, then moving this process to the home station would likely produce a better yield at a critical time when this information needs to be captured in order for prompt and effective treatment to be administered. If necessary and appropriate, the examining health care provider in coordination with the National Guard J-1 and State's Surgeon General can cause the member to be retained on active duty locally for further treatment and evaluation.

This is especially critical in screening for behavioral conditions. At all stages of PTSD and depression, treatment is time sensitive but this is particularly so after onset as the illness could persist for a lifetime if not promptly and adequately treated and could render the member permanently disabled. The effects of this permanent disability on the member's entire family can be devastating. It is absolutely imperative that members returning from deployment be screened with full confidentiality at the home station while

still on active duty by trained and qualified mental health care providers from VA staff and/or qualified health care providers from the civilian community that could include primary care physicians, physician assistants and nurse practitioners who have training in assessing psychological health presentations. Prompt diagnosis and treatment will help to mitigate the lasting effects of mental illness.

Please see the copy of a November 5, 2008 electronic message to NGAUS from Dr. Dana Headapohl set forth in the Appendix which strongly recommends a surveillance program for our members before they are released from active duty. Dr. Headapohl opines the obvious in stating that **inadequate medical screening of our members before they are released from active duty is "unacceptable to a group that has been asked to sacrifice for our country." (emphasis added)**

Recommendation:
The National Guard Association of the United States recommends that Congress support authorization and appropriations for programs that will:

- Require the Post Deployment Health Assessment for National Guard members to be administered at the home station before releasing members from active duty
- Mandate medical and behavioral screening of all National Guard members returning from deployment by health care professionals at the home station before releasing the members from active duty.

Embed Mental Health Care Providers in Armories and Reserve Centers During Drill

National Guard and Reserve suicides nearly doubled from 80 deaths n 2009 to 145 deaths in 2010. This highest suicide rate in the military underscores the need to provide the National Guard and Reserve with convenient access to mental health care providers in a command supported local setting.

Using the National Guard and Reserve as an operational force in the current war requires a funded mental health readiness care program during dwell time in order to maintain an important component of medical readiness required by deployment cycles.

As our members reintegrate into their civilian communities or prepare for future deployments, many show no signs of physical injury but suffer from

the psychological effects of traumatic stress requiring treatment. These psychological effects may range in severity from behavioral readjustment concerns to post traumatic stress disorder (PTSD) with some conditions not manifesting themselves until months or even years after returning from deployment. Early referral and treatment of behavioral and PTSD issues are essential for positive outcomes.

The Department of Defense must provide better access for all National Guard and Reserve members during duty hours to seek the assistance of mental health care professionals in a convenient stigma free environment. Increased access would more thoroughly and expeditiously identify members in need of treatment.

Embedding mental health care providers in armories and Reserve training centers during drill would enable on site self referrals or mandatory unit wide referrals which would mitigate the perceived stigma associated with National Guard members individually seeking mental health counseling. This would also eliminate the need for our members take medical leave and drive potentially great distances to seek similar services during the during the work week. As states with piloted programs attest, the embedded mental health care provider program works.

Tri West with its own funds has instituted a pilot program in California that supports 27 mental health care providers as embedded screeners with 40 California National Guard units to provide support and referral assistance during drill weekends and family readiness events. These providers can earn the trust of soldiers and build relationships through regular contact in a familiar environment. For those National Guard and reserve members and their families who may not have access to the support and resources more commonly found in active duty military communities, this outreach is particularly important. The pilot program offers soldiers a greater access to the type of care they are most comfortable seeking.

S. 325, The Embedded Mental Health Providers for Reserves Act of 2011 introduced by Senators Patty Murray and Claire McCaskill, now before the 112th Congress would require the Service Secretaries to provide to any and all members of the reserve components performing inactive-duty unit training access to mental health assessments and treatment with a licensed mental health professional who would be available for referrals during duty hours on the premises of the principal duty location of the member's unit.

The Congressional Budget Office has preliminarily estimated the five year outlay for S. 325 to be 109 million dollars. Secretary Gates has requested 677 million dollars in the Presidents' FY 2012 Budget for treatment of PTSD and TBI. A fair allocation of this sum and future requests should more than cover the cost of S. 325. In light of the recent GAO castigation of the waste and lack of direction in the Defense Center of Excellence, the embed program offers a bargain in caring for the mental health needs of deserving members of the military. Congress needs to require DoD to fairly share mental health appropriations with the National Guard and Reserve who can apply those funds efficiently with an embedded provider program.

Our young men and women deserve appropriate and timely mental health care assessments and care as they attempt to reintegrate into civilian life and maintain medical readiness for future deployments.

Recommendation:
Support the passage of **S. 325**.

Equitably Amend the 2008 National Defense Authorization Act in Reducing the Age for Members of the Reserve Components to Collect Retirement Pay

Having transitioned to an operational force, the National Guard of the United States is spending more time on active duty as it shares responsibility for the current wars.

More than sixty years ago, the Congress of the United States established the age limit for receipt of retired pay by Reserve component members. That law, most recently amended in the 2008 National Defense Authorization Act, states that a retired Reserve component member can begin to draw military retired pay upon reaching 60 years of age regardless of number of years served. A National Guard member who enlists after high school at age 18 and retires after 20 years of service at age 48 must wait 22 years before drawing a retirement check.

Retroactivity

Led by the efforts of Senator Saxby Chambliss, the Fiscal Year 2008 National Defense Authorization Act reduced the 60 year eligibility age for retired members of the Ready Reserve to collect retirement pay three months for each aggregate of 90 days per fiscal year of active duty performed in Title 10 status in support of a contingency operation or in Title 32 status in responding to a national emergency. Unfortunately, these historic provisions applied only to service after January 28, 2008, the date of enactment of the 2008 NDAA. Making these changes fully retroactive to 9/11 is the number one benefit issue in the Guard and Reserve.

Since September 11,2001members of the Reserve Component have continued to serve as an "operational" force with their active counterparts in Iraq, Afghanistan and other dangerous locations around the globe. If active duty service of the Reserve Components in wartime and national emergencies after January 28, 2008 is now recognized in reducing the age to collect military retirement pay, it is inequitable to not credit retroactively all otherwise qualifying service performed after September 11, 2001. Those members currently deployed who fought in OIF/OEF before January 28, 2008 know painfully that their earlier service is not truly respected. Our members who so bravely risked their lives in service to our country deserve that respect.

The Congressional Budget Office last year estimated the cost of a bill to provide retroactivity be 1.353 billion over ten years. NGAUS understands that Reserve retirement is considered mandatory spending which would require passage of a retroactivity bill to have an offset commensurate with its estimated cost.

In the event the Senate fields a bill this session that would establish the subject retroactivity, NGAUS urges Congress to please search for an offset to fund this necessary legislation, or in the event a War Supplemental Bill should be introduced this session, to fund such a bill as an emergency spending measure.

Eliminating the Fiscal year Requirement for 90 Days of Qualifying Service

The Fiscal Year 2008 National Defense Authorization Act requires the aforementioned 90 days of qualifying service to occur within a single fiscal

year thereby unfairly not crediting otherwise qualifying service spread over two fiscal years.

For example, if one served 90 days in OIF from September 1, 2008 through November 29, 2008, that service would not be credited in reducing the retirement eligibility age. However, if the person served 90 days in OIF from October 1, 2008 through December 29, 2008, that service would be fully credited. This distinction unfairly penalizes those who serve bravely with orders spanning two fiscal years.

NGAUS urges Congress to correct this inequity by fully crediting each aggregate of 90 days of qualifying service irrespective of the fiscal year in which it is served.

Recommendation:
The National Guard Association of the United States recommends that the Congress of the United States support legislation to make the Reserve retirement law changes in the Fiscal Year 2008 National Defense Authorization Act (NDAA) retroactive to 9/11 and to eliminate the fiscal year requirement for the 90 days of qualifying service to reduce the eligibility age.

Space Available Travel Priority on Parity with the Active Force

A popular misconception on the Hill holds that Space Available (Space A) aircraft travel is governed exclusively by DoD Joint Travel Regulations (JTR). Although the JTRs establish the priority categories, Congress does intervene with statutory corrections from time to time to redirect the Secretary of Defense to reestablish equitable travel priorities. Attached to this written testimony is a copy of t 10 USC Section 2641b which did just that relative to travel to receive specialty care.

Another statutory change in Space A priorities is in order to bring members of the National Guard and Reserve and their dependents on level Space A priority with the active forces and their dependents. DoD would still establish priority categories in the JTR but whatever priority category assigned to the active forces on leave and their dependents would by law apply to the National Guard and Reserve members and their dependents.

The National Guard has established itself as an indispensable operational force in defending our country in a most cost effective manner. Serving shoulder to shoulder with the active component worldwide, members of the National Guard as citizen soldiers remain ready to uproot from their families and civilian lives to serve their governor domestically or their President in distance parts of the globe as duty calls and to return to the same communities when their missions are accomplished.

In recognition of this service, Congress has worked hard since September 11, 2010 to establish federal legislation to close the benefit gap that exists for our deserving members and their families. Expanding space-available travel for our members and gray area retirees would be a significant step in that direction. It appears that the bills would also be budget neutral.

S. 542 introduced by Senator Mark Begich would provide space-available travel on defense department aircraft for members of the reserve components on the same basis as active members of the armed forces; retired members of the reserve component eligible to receive retirement pay but for age on the same basis as retired members of the armed forces entitled to receive retirement pay; widows of retired members entitled or eligible to receive retirement pay; and the accompanying dependents of these members, retired members or widows. This legislation is likely budget neutral.

Recommendation:
Please support the passage of **S. 542**.

Extend TAMP Coverage with TRICARE Prime Remote

Post deployment care for members under the Transitional Assistance Management Program (TAMP) and their families must be for a period equal to the period of deployment but not less than six months. The TAMP program allows members to obtain at government expense up to six months of TRICARE coverage that is similar, but not identical, to the TRICARE Prime coverage they had been receiving on active duty.

Effective TAMP coverage is a medical readiness issue for the overwhelming majority of our returning members who are subject to redeployment and must maintain their medical and dental readiness. Unfortunately, many are slipping through the cracks post deployment with undiagnosed medical conditions, particularly behavioral conditions, which may not be reported by

the returning members when they self assess their medical condition on the Post Deployment Health Assessment (PDHA) administered at the demobilization site. Unreported conditions cannot be treated. As these conditions become known over time, a reasonable period is needed for proper treatment. The current six month TAMP period is proving to be inadequate either because of other demands on the returning members' time or the late disclosure of a service connected injury.

The coverage available under TAMP does not include access to the provider network under TRICARE Prime Remote, the rural active duty coverage available to family beneficiaries while the military sponsor is deployed. This breaks provider continuity for rural beneficiaries switching to TAMP post deployment who had been treating under the TRICARE Prime Remote program while the military sponsor was deployed. This requires many of our rural families who had been using TRICARE Prime Remote during the deployment to search for a new provider and hopefully find one. The TAMP program need adjusting to expand its provider network and to specifically allow rural beneficiaries to have access to the same TRICARE Prime Remote providers they had been using.

Recommendation:
It is the recommendation of the National Guard Association of the United States that the Congress of the United States support funding and authority for:

- Extending post deployment TAMP coverage for a period equal to the period of deployment but not less than six months.
- To include access to the TRICARE Prime Remote provider network as part of the TAMP coverage benefit.
- To expand the TRICARE provider network.

Conclusion

In conclusion, we at NGAUS hope that we have both reinforced and amplified this Sub Committee's understanding of personnel needs of the National Guard. Thank you again for the opportunity to submit testimony to this Subcommittee and for all that you do for our nation's service members.

APPENDIX

Colonel Duffy - I am sending links to articles a
bout the importance of providing medical surveillance examinations for workers in jobs with specific hazardous exposures. I believe this approach could be modified to evaluate National Guard members returning from Iraq and Afghanistan for PTSD, TBIs and depression.

The OSHA medical surveillance model includes the following basic elements:
1. Identification of potential hazardous exposures (chemical, physical, biologic).
2. Screening workers for appropriateness of placement into a specific work environment with such exposures. For example, individuals with compromised liver functions should not be placed in environments with unprotected exposures to hepatotoxins.
3. Monitoring workers after unprotected exposure incidents. Examples- monitoring pulmonary function in an worker exposed to a chlorine gas spill, or following hepatitis and HIV markers in a nurse after a needle stick injury.
4. Conducting exit examinations at the end of an assignment with hazardous exposures, to ensure that workers have not suffered adverse health effects from those exposures.
(including concussive explosions or other traumatic events).
Surveillance exams of all types (OSHA mandated surveillance programs, population health screening for chronic disease risk factors) have been a part of my practice of Occupational and Preventive Medicine in Montana for the past 22 years. Early diagnosis and treatment is especially essential for potential medical problems facing military members serving in Iraq and Afghanistan - post traumatic stress disorder (PTSD), traumatic brain injury (TBI) and depression. Timely diagnosis and aggressive treatment is essential especially for these problems, to maximize treatment success and functioning and to mitigate suffering.

There are a number of organizations that design and implement medical surveillance programs. There is no reason the same approach could not be applied to the specific exposures and potential medical problems facing National Guard troops in Iraq and Afghanistan. With proper program design and local provider training, this program would not need to be costly. In my clinical experience, male patients especially are more likely to report symptoms of PTSD, TBI, or depression in the context of an examination rather than questionnaire. Findings can present subtly, but if untreated can have devastating effects on the individual, family and work place.

In my practice, I have seen a number of Vietnam veterans, and more recently National Guard members who have returned from deployment in Iraq or Afghanistan, who have been inadequately screened and/or are suffering unnecessarily because of geographical barriers to adequate treatment. This is unacceptable treatment of group that has been asked to sacrifice for our country. They deserve better.
I applaud your organization's efforts to lobby for better post deployment screening and treatment of the National Guard members returning from Iraq and Afghanistan.

Dana Headapohl MD

http://www.aafp.org/afp/20000501/2785.html
https://www.desc.dla.mil/DCM/Files/OSRHealth%20Medical%20Exam_1.pdf This is about military surveillance exams.
http://www.lohp.org/graphics/pdf/hw24en06.pdf
http://www.cdc.gov/niosh/sbw/management/wald.html
http://www.ushealthworks.com/Page.aspx?Name=Services_MedSur

---PRELIMINARY---

Cost Estimate of S. 325 / H.R. 948, Embedded Mental Health Providers for Reserves Act of 2011
As Introduced on February 10, 2011 (S. 325) and March 8, 2011 (H.R. 948)

Spending Subject to Appropriations
(by Fiscal Year in Millions of Dollars)

	2012	2013	2014	2015	2016	2012-2016
Estimated Authorization Level	6	26	27	29	30	119
Estimated Outlays	5	22	26	28	29	109

NOTES:

1. Would require the reserves to have mental health counselors available during drill weekends and inactive duty training.
2. Estimate is based on cost of pilot programs run by TriWest.
3. CBO estimates this legislation would not impact direct spending or revenues.
4. Assumes enactment near the start of fiscal year 2012.

CBO Staff Contact: Matt Schmit, x65708
3/31/2011 11:01

---PRELIMINARY---

§ 2641b. Space-available travel on Department of Defense aircraft: retired members residing in Commonwealths and possessions of the United States for certain health care services

(a) Priority Transportation.— The Secretary of Defense shall provide transportation on Department of Defense aircraft on a space-available basis for any member or former member of the uniformed services described in subsection (b), and a single dependent of the member if needed to accompany the member, at a priority level in the same category as the priority level for an unaccompanied dependent over the age of 18 traveling on environmental and morale leave.

(b) Eligible Members and Former Members.— A member or former member eligible for priority transport under subsection (a) is a covered beneficiary under chapter 55 of this title who—

(1) is entitled to retired or retainer pay;

(2) resides in or is located in a Commonwealth or possession of the United States; and

(3) is referred by a military or civilian primary care provider located in that Commonwealth or possession to a specialty care provider for services to be provided outside of that Commonwealth or possession.

(c) Scope of Priority.— The increased priority for space-available transportation required by subsection (a) applies with respect to both—

(1) the travel from the Commonwealth or possession of the United States to receive the specialty care services; and

(2) the return travel.

(d) Definitions.— In this section, the terms "primary care provider" and "specialty care provider" refer to a medical or dental professional who provides health care services under chapter 55 of this title.

(e) Regulations.— The Secretary of Defense shall prescribe regulations to implement this section.